Physician's Report of a HBsAg-Positive Woman
CONFIDENTIAL

Fax to: Contact Person
Title
Local Health Department

FAX: (###) ### ####
Phone: (###) ### ####

Patient Information

Name:

_____

DOB: ____/____/____

Address:

_____

_____

_____

Phone number:
(_____) _____

Emergency contact number:
(_____) _____

Preferred language:

_____

Is patient pregnant?:
☐ Yes
☐ No

If yes,
EDC: ____/____/____
Expected delivery hospital:
_____

Patient's Test Results

HBsAg	Result:_____	Date:_____
anti-HBc	Result:_____	Date:_____
anti-HBc IgM	Result:_____	Date:_____
anti-HBs	Result:_____	Date:_____
HBeAg	Result:_____	Date:_____
HBeAb	Result:_____	Date:_____
HBV DNA	Result:_____	Date:_____

Testing Laboratory: _____
Laboratory Contact Name: _____
Laboratory Contact Number: _____

Provider Information

Provider's Name:

_____

Provider's Address:

_____

_____

_____

Provider's Phone Number:

(_____) _____

Provider's Fax Number:

(_____) _____

Reported By

Name: _____

Phone Number: (_____) _____